Expert Advisory Committee
Tuesday November 22, 2011
8:00am – Healthcentric Advisors
Mtg Minutes

Attendees: Elaine Jones, Jennifer Wood, Monica Neronha, Jim Borah, Linda McGolderick, Jane Hayward, David Keller, Kathryn Shanely, Joan Kwiatkowski, Chris Koller, Mark Reynolds, Brian Pagliaro, James Raiola, Bill Delmage, Doug Harrison, Lynne Dunphy, Beth Lange, Elizabeth Earls, Craig Syata, Nick Tsiongas, Christine Ferguson (via conference call), John Fleig (via conference call)

I. Call to Order and Overview – Dan Meuse, Office of Lt. Governor

   a. Mr. Meuse called the meeting to order and asked the group to go around the room and introduce themselves. Dan explained that this Expert Advisory Committee will receive presentations from interagency staff, and then will debate and discuss. Their recommendations and discussions will be reported up to the Health Benefits Exchange Board

II. Policy Considerations Regarding Reinsurance, Risk Corridors and Risk Adjustment (Presentation by Mr. Meuse, available here)

   a. Risk Adjustment Discussion/Questions
      i. The idea that the individual and small groups must exist inside and outside the exchange, is that a federal requirement? Yes. The rationale was that inside and outside the exchange are treated individually no matter what. The ACA is clear that regardless of inside or outside the exchange the parties are treated equally.
      ii. The benefit is for a state run program is that we would have the opportunity to change the weights for the programs. Tailor the risk score to the RI market. From a cost burden perspective there is going to be an administrative allowance on the federal side and on the state side, neither of which we are quite sure of the sum.
      iii. Will the federal government give the state funding for doing our own state run program? We know that there are funding needs to get it up and running, and it is plausible that if we say to the feds that we need funds to, for example, get the APCD up and running, then we may receive funds. It is not the same as the Exchange where the feds give the state a check and say, "go, build your program." A key resource RI has is being part of the RWJF state networks program.
      iv. Has there been any thought yet to how the risk corridors and the risk adjustment will work together at least in terms of

retrospective? We do not know the complete answers, as we do not have the final rules and outlines, but any analysis of the effects of the programs cannot be considered mutually exclusive.

v. Concerns were expressed about the timing for these decisions - simile that it is like building an airplane as it is flying. Mr. Meuse asked the group consider at the timing the state has for its legislative cycles, the timing typical for the state to implement a program, it requires us to work well in advance to give enough room for adjustment. He conceded it is difficult – trying to make decisions without the final guidance from federal agencies. RI is in a good place as it is a "pace car" of sorts for other states.

b. Reinsurance – important to note that when RI elected to run its own Exchange, it was consequently required to run its own reinsurance program.
   i. Should RI run its own Risk Adjustment program, and if so are their conditions that need to be placed on it?
   ii. If the state makes the decision to do its own Risk Adjustment program, is it irrevocable? No, if years down the road the federal program appears better than the RI program the state can elect to dismiss its own and take up that fed program.
   iii. At a recent Executive Committee meeting, the issue of resources needed to take on these programs came up. Has their been further discussion of how many FTEs will be needed, what the budget may be, etc? First point, even if we have the federal program take the lead, the state would need to send an administrative allowance. Waiting on an in-depth work plan from Wakely with concepts to think about projections.
   iv. Are the carriers permitted to listen in on Wakely Consulting calls and planning calls for risk adjustment? If so it would be really beneficial to take part in those calls. Mr. Meuse noted that if it is permitted by the state network then that is permissible. Will look into it.
   v. Diagnosis least important driver of risk in the 133% FPL population – so diagnosis codes going into risk adjustment may need to be reconsidered. Thus far federal guidance suggests the codes will be just diagnosis codes and pharmaceutical codes. It may be that a state program may have additional benefits.

III. Policy Considerations Regarding the Basic Health Plan Option - Presentation by Deb Faulkner (available here)

a. This modeling hasn't yet included the price sensitivity or elasticity, or was it modeled based on exchange costs? Modeled based on regional New England incomes, does not get down to the level of charging a bit more for BHP should there be more take up. Important next step will be to obtain the data on likely take up.

b. In terms of the modeling, is there a plan to go further into the modeling, do we have the resources to go forward to locate this? The time frame to obtain meaningful data would have to be relatively soon, where would be in that process? Working on getting an RFP to move that work forward; hope might be able to leverage the work from the Urban Institute and other think tanks. The challenge is that RI is so small, making it difficult for a comparable state.

c. When we describe the BHP option for RI, the way that RI has, yes might be slightly different from the fed program, but it would all be one ID card for each person (parent BHP, child RIte Care, etc). Difference between having the same card and literally having coverage of the same benefits – that is the concern that the BHP doesn't sound like that. The BHP in concept would enable the line to be at 200% where there is a more substantial shift. It in some ways moves that line. The policy decision is where to draw that line for better management of the population, for it to be useful how to align those programs so that it works.

d. Public Comment: Disabled population important.

e. All of the numbers presented presume because the federal law allows it but doesn't require it, that we move those off Medicaid into different programs i.e. the exchange or the BHP. This result should be cheaper for the state – there are big savings that should be noted. There is also 100% reimbursement for the new categories of reimbursement, but inevitably RI will see savings in the 2014. In MA they are seeing so much savings from reform that they are now looking where to spend it.

f. Affordability for the parent of a child who has RIte Care, is the benefit so basic that there will be significant out-of-pocket costs? There are two underlying sources of benefit structures. The essential benefits package or then the existing benefit structure – not sure at this time what the BHP will be built upon, likely the essential benefits package, yet that package has not yet been defined.

g. Looking at the pros and cons, have not heard a lot about reimbursement rates and sensitivity to that issue - reactions to that

issue? Is there a concern about this population moving into a Medicaid-like expansion program, or an exchange?

i. Dr. Tsiongas – not a significantly large group of people 19K not a huge issue for physicians, if attenuated by the fact that some may not buy that.
ii. Dr. Lange – the 19K will affect different populations different ways. The word reimbursement is the vernacular used in industry, but consider that this is about physicians who are being paid, not reimbursed.
iii. Churn, people who are "walking" the BHP or uninsured line. At the 133% FPL, 60% will flip at one time. That is significant. The numbers are less at the 200%FPL mark
iv. This issue of having three kinds of plans is potentially very different requirements, as well as a benefit structure will have a profound affect. Mark Reynolds disagreed noting may not even be 19K, may be 10K who fall into this structure. The whole purpose here is to design a benefit structure that mitigates the differences. The whole intent is to create a system that looks like RIte Care, that doesn't have a different look. Disagree that is a breakup of the system – it is an adjustment. Christy Ferguson noted that she is addressing the differentials, not just the benefit issues, and trying to understand what is happening at the provider level, will there be different rates.

IV. Jennifer Wood called advised time allotted for this meeting had ended and noted that we need more modeling, done on more sensitive variables. We have in the works contracting to have the modeling done, really confronting a weird collision of decision making timelines working backwards from 2014 with anything that has legislative implications at the state level, as only have two leg session between now and when the exchange will be up in RI. As a result there may be asking of the general assembly to authorize developing a BHP based on a number of variables TBD at a later date by the feds. Thus request the group look at the presentation, and consider the important contingencies. What are the triggering events, what are the conditions, such that not getting too far out of the lane.

V. Adjourn